K4D | Knowledge, evidence and learning for development

Health-seeking behaviour focusing on reproductive, maternal, newborn, and child health (RMNCH) services[1]

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Question

What are the lessons learned, achievements, and challenges from interventions funded by DFID and other donors to improve health-seeking behaviour focusing on RMNCH services?

Contents

[1] This rapid review is part of a three-part series related to reproductive, maternal, newborn, and child health (RMNCH).

1. Summary

This rapid review is one of a three-part series related to reproductive, maternal, newborn, and child health (RMNCH) interventions. The other two rapid reviews include information on gender norms and barriers affecting demand for RMNCH services in Ethiopia and other developing countries (Birch, 2020; Browne, 2020). Therefore, those topics will not be discussed in detail here. Consequently, this rapid review will focus on lessons learned from donor-funded interventions in Ethiopia and the surrounding region, specifically for pastoral communities.

Key points on achievements and challenges to highlight:

- **Health extension workers (HEWs)** and **health development armies (HDAs)** are very trusted in RMNCH interventions (World Bank, 2016; Asfaw et al., 2019). This finding adds to the growing body of evidence that health workers at the community level can work with women's groups to improve maternal health, thus reducing the need for emergency obstetric care in low-income countries (Jackson et al., 2016).
- Most donor RMNCH interventions in Ethiopia involve **using HEWs to improve health-seeking behaviour**, e.g. AusAID, DFID, Global Affairs Canada, and USAID (Jackson et al., 2016; Asfaw et al., 2019; Jalu et al., 2019). However, HEWs are not always available at health posts, as almost all their time is spent providing outreach community services (Jalu et al., 2019). **Top-down supervision and provision of training** is important to improve relationships between HEWs and *woredas* (districts) (Diaz et al., 2018; Kok et al., 2015).
- Community study findings from Ali & Woldearegai (2019) imply the presence of a **positive health-seeking behaviour among pastoralists** to using modern health services, which can be further strengthened with interventions promoting these services.
- Elmusharaf et al. (2015) suggest three challenges that need to be addressed to create a supportive environment in which demand-side strategies can effectively improve access to maternal health services. These are: **addressing decision-making norms, engaging in intergenerational dialogue,** and **designing contextually appropriate communication strategies.**
- **Disability of mothers and children** also needs to be addressed: research shows that Ethiopian caregivers are often worried about being treated differently, feeling ashamed or embarrassed about their child's condition, and make efforts to keep their child's condition a secret rather than seek health services (Miftah et al., 2017). Neither previous or current national Reproductive Health Strategies in Ethiopia include information on achieving improved health-seeking behaviour for women with disabilities.

There is a dearth of evidence available focussing on intervention design strategies in Ethiopia. However, lessons learned are available from other countries/regions:

- In Kenya, JICA funded MCH handbooks (Kawakatsu et al., 2015) and women's self-help groups used by USAID-funded research in Uttar Pradesh, India have been successfully used to improve RMNCH health-seeking behaviour (Araldus et al., 2017).
- One project funded by USAID and NORAD, the *Results-based Financing for Maternal and Neonatal Health (RBF4MNH) Initiative*, Malawi - which has community health workers (CHWs) rather than HEWs - did not report greatly improved use of services.

Results from an evaluation on the Initiative found this to be due to **insufficient programme structure and staff** (Jordan-Harde, 2013).

- Improving early antenatal attendance requires **integrated interventions** that address both community and health systems barriers, including spouses (Maluka et al., 2020). **Greater communication** between communities and service deliverers is also essential in improving RMNCH seeking behaviour (Zwi et al., 2009).

2. Introduction

Health-seeking behaviour

Healthcare-seeking behaviour (often shortened to 'health-seeking behaviour, HSB' or 'care-seeking behaviour') has been defined as "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy".[2] It can also be referred to as 'illness behaviour' or 'sick-term behaviour' (Latunji & Akinyemi, 2018).

Health-seeking behaviours are intricately linked with the health status of a nation, and thus its economic development (Latunji & Akinyemi, 2018). Health-seeking behaviour is not an isolated event decided by individuals focusing merely on their self-interest. Rather, it is "part and parcel of individuals, families or community's identity, which involves a combination of social, personal, cultural and experiential factors" (Ali & Woldearegai, 2019: 292). Health-seeking behaviour is situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill health, as well as dealing with any departure from a good state of health.[3]

The high maternal and newborn mortality in Ethiopia is due to delays in (i) seeking skilled emergency obstetric care; (ii) reaching the health facility, and (iii) receiving timely intervention after reaching the facility (Government of Ethiopia & UN Ethiopia, 2014: 47). Appropriate health care-seeking behaviour of mothers/guardians for common childhood illnesses could prevent a significant number of child deaths and complications due to childhood illnesses. However, there are few studies exploring such demands or behaviours in Ethiopia (Simieneh et al., 2019).

Pastoral communities and health-seeking behaviour

Pastoralism is a form of animal husbandry, historically practiced by nomadic people who moved with their herds. In Ethiopia, this livestock includes cattle, camels, goats, horses, and sheep. This rapid review is focusing on data for health-seeking behaviour of pastoral communities in Ethiopia.

The pastoralist population resides in six regional states of Ethiopia: Somali, Afar, Oromia, Southern region, Gambella, and Benishangul-Gumuz (Ahmed et al., 2019). Overall, in developing/pastoralist regions in Ethiopia, the number of health facilities is limited, unevenly distributed, and often falls short of providing a minimum package of primary healthcare services.

[2] Olenja J (2004). Editorial: Health seeking behaviour in context.

[3] MacKian S (2003). A review of health seeking behaviour: problems and prospects. Health Systems Development Programme.

Most facilities operate at a level far below their intended capacity and are poorly organised, staffed, and managed, resulting in an extremely low use rate (FMOH/WHO/UNICEF, 2011). In addition to the pastoralist lifestyle of seasonal mobility, difficulties associated with transportation and communications prevent people in pastoral areas from using services.[4] Where services are available and accessible, their use is also extremely low, indicating low health-service-seeking behaviour and practices (Government of Ethiopia & UN Ethiopia, 2014: 39).

RMNCH in pastoral communities

Although maternal reproductive, maternal, newborn, and child health (RMNCH) service figures are a vast improvement over 2003 rates, when the country's flagship Health Extension Programme was launched, many studies have shown that the health-seeking behaviour and service utilisations of Ethiopia are poor compared to other African regions (Janu et al., 2019). Researchers have observed that while there are large variations, care-seeking for newborn illnesses in Ethiopia appears to be low in general and highly contextual (Sibley et al., 2017).

Evidence indicates that Somali regional state's health-seeking behaviour and service utilisations are the worst health indicators nationally (Janu et al., 2019). After Afar, the Somali region has the second highest teenage pregnancy (22%), and the second lowest immunisation rates (48%). Both the Contraceptive Prevalence Rate (CPR) and antenatal care are the lowest in the Somali region (2% and 12%, respectively); with the highest percentage (23%) of children with wasting. An Ethiopian demographic health survey recorded 14.7% institutional delivery in Afar, compared to Tigray (56.9%), a neighbouring predominantly agrarian region (CSA & ICF, 2016).[5]

3. Donor interventions improving RMNCH health-seeking behaviour

The following section summarises the achievements and challenges of health-seeking behaviour interventions by international donors, which focus on improving use of RMNCH services. Examples are provided from Ethiopia as well as other countries:

Ethiopian case studies

AusAID/DFAT: Improving the use of maternal, neonatal and child health services in rural and pastoralist Ethiopia

This research was funded by the Australian government's Department of Foreign Affairs and Trade (DFAT) through the Australian Development Awards Scheme, under an award titled *Improving the use of maternal, neonatal and child health services in rural and pastoralist Ethiopia*

[4] This is further intensified by less identified and understood cultural, social, and behavioural determinants that may harm healthcare practices, including health-seeking behaviour (Government of Ethiopia & UN Ethiopia, 2014: 37). Further details can be found in Browne (2020) and Birch (2020).

[5] It is worth noting that Tigray was where the ruling party (Ethiopian People's Revolutionary Democratic Front, EPRDF – which included the Tigray People's Liberation Front, TPLF) came from, and they are known to have concentrated development in their region.

(AusAID Agreement 66420). 16 health extension workers (HEWs) were trained to interview 45 women about maternal health-seeking behaviour in Adwa *Woreda* (district), Tigray Region.

Achievements: With the support of Women's Development Groups, HEWs increased the rate of skilled birth attendance by calling ambulances to transfer women to health centres either before their expected due date or when labour starts at home. These findings add to the growing body of evidence that health workers at the community level can work with women's groups to improve maternal health, thus reducing the need for emergency obstetric care in low-income countries (Jackson et al., 2016).

Challenges: Although a woman's mother, grandmother, mother-in-law or older relative will stay with her, the husband is still considered the key person who favours seeking healthcare (Jackson et al., 2016). Due to this situation, the decision-making power of women is reduced in the absence of their husbands, especially the cost incurred for transportation and other fees other than the healthcare costs. Thus, women could be influenced to stay at home and prefer the traditional model of care instead of the medical model.

DFID: Exploring barriers to reproductive, maternal, child and neonatal (RMNCH) health-seeking behaviours in Somali region, Ethiopia

This DFID-funded study aimed to explore factors affecting health-seeking behaviours in the Somali regional state of Ethiopia. The study employed a cross-sectional study design using qualitative data collection tools. Data were collected from 50 individual interviews and 17 focused group discussions (FGD) on women of reproductive age and their partners, HEWs, healthcare providers and health administrators. To ensure representativeness, the region was categorised into three zones based on their settlement characteristics as agrarian, pastoralist, and semi-pastoralist (Jalu et al., 2019).

Achievements: This study highlighted that RMNCH service-seeking behaviour of the Somali region community was chiefly affected by **residential area** and the **socio-cultural and economic characteristics of the community**. For instance, in urban settings, people are aware of the availability of the service and have easy access to use services because they have some exposure to health information either through media, healthcare providers, or through their peers (Jalu et al., 2019).

Challenges: In places where there was an option of both hospitals and other primary healthcare units (PCHU), the healthcare providers interviewed stated that mothers do not use the delivery services for fear of invasive procedures like instrumental delivery and caesarean section. The few individuals who do use institutional delivery prefer to go to hospital rather than using the nearby health post[6] or health centre (Jalu et al., 2019). Furthermore, the HEWs are not always available at the health post as almost all their time is spent providing outreach community services.

[6] Health posts are part of primary level healthcare. The health post is under the supervision of the district health office and the kebele administration and receives technical support from the nearby health centre (Assefa et al., 2019).

Global Affairs Canada: The Innovating for Maternal and Child Health in Africa (IMCHA) Initiative[7]

This study is jointly funded by the Canadian Institutes of Health Research, Global Affairs Canada, and the International Development Research Centre (IDRC). It consists of two inter-related programme components: Implementation Research Teams (IRTs), and Health Policy and Research Organisations (HPRO).[8] Twenty IRTs are in west (7) and east (13) Africa. The *Moving Maternal, Newborn, and Child Health Evidence into Policy in East Africa* project, which is part of the IMCHA Initiative, includes Ethiopia, Malawi, Mozambique, Tanzania, and South Sudan.

Achievements: Qualitative data from the *Safe Motherhood Research Project*, funded through the IMCHA Initiative, shows that **HEWs and Health Development Army (HDA)**[9] are thought of as trusted health messengers (Asfaw et al., 2019). Regarding communication channels, participants primarily favoured face-to-face/interpersonal communication channels, followed by mass media and traditional approaches like community conversation, traditional songs, and role play.

Challenges: There is no evidence available for IMCHA in Ethiopia. However, qualitative analysis from the IMCHA Initiative in Tanzania shows that while the spouse accompany policy is important, the implementation of this policy should not infringe women's rights to access antenatal services (Maluka et al., 2020).

USAID: The Maternal and Newborn Health in Ethiopia Partnership (MaNHEP)

In 2014, the United States Agency for International Development (USAID) and University Research Company, LLC, initiated a new project under the broader Translating Research into Action portfolio of projects. This new project was entitled *Systematic Documentation of Illness Recognition and Appropriate Care Seeking for Maternal and Newborn Complications*. This project used a common protocol involving descriptive mixed-methods case studies of community projects in six low- and middle-income countries (LMICs), including Ethiopia. MaNHEP, which was funded through this project, was a 3.5-year project aimed at developing a community-oriented model to improve maternal and newborn survival in rural Ethiopia.

Achievements: MaNHEP was associated with more and better interactions and relationships among HEWs, community health workers (CHWs) and the community (Assefa et al., 2019). There were significant improvements in awareness, trust, and completeness of care (Sibley et al., 2014). The HDA supported HEWs in liaising with community members. **Top-down**

[7] https://www.idrc.ca/en/initiative/innovating-maternal-and-child-health-africa

[8] Innovating for Maternal and Child Health in Africa (IMCHA). NETWORK OF AFRICAN PARLIAMENTARY COMMITTEES OF HEALTH (NEAPACOH) MEETING. 28 June 2017. http://www.partners-popdev.org/wp-content/uploads/2017/11/Overview-of-IMCHA-PPD.pdf

[9] The HDA represents a systematic, organised, and collaborative movement through active participatory learning and actions to improve health. The HDA has been providing an effective platform to engage the community in the planning, implementation, monitoring, and evaluation of health and other programmes in Ethiopia since 2012. A functional HDA requires health development teams (HDTs) that comprise up to 30 households residing in the same neighbourhood. The HDT is further divided into smaller groups of six members, commonly referred to as one-to-five networks. HEWs and Kebele administrations facilitate the formation of HDTs and one-to-five networks. Volunteer CHWs (including traditional birth attendants, health promoters, and reproductive health agents) help HEWs in mobilising the community (World Bank, 2016).

supervision and provision of training improved relationships between HEWs and *woreda* health offices in 2015 (Diaz et al., 2018; Kok et al., 2015).

Sibley et al. (2014) found significant improvements in women's awareness and level of trust in the ability of HEWs to provide care, in the completeness of care women received, and in their use of skilled providers or HEW for antenatal and postnatal care. Successful local solutions for pregnancy identification, antenatal care registration, labour-birth notification, and postnatal follow-up were adopted across 51 project *kebeles* (communities) (Sibley et al., 2017).

Challenges: A descriptive case study employing mixed methods was the appropriate approach for answering the questions posed in this research. Compared with other methods, it permits a better understanding of the changing patterns of care-seeking over time, in relation to events. Yet, the approach was challenging to use. Challenges include selecting the **guiding framework** and relevant data sets to address the questions, as well as development of and rigorous adherence to different types of data collection and analytic procedures. Most of these challenges had to be addressed through a series of workshops hosted and led by the USAID/University Research Company team (Sibley et al., 2017).

International case studies

DFAT/USAID Timor-Leste HealthCare-Seeking Behaviour Study

Despite significant improvements, health status in Timor-Leste is poor (Zwi et al., 2009). The aim of this multi-funded study was to promote health-seeking behaviour (including knowledge of causes of illness and healthy behaviour, types of services available and how to access services). This was through **interpersonal communication**; educational materials for use by CHWs; community mobilisation (training; participatory planning), and 'edutainment' (drama, theatre) (Butterworth, n.d.: 9). The focus was on general healthcare-seeking and preventive health practices; MCH, in particular childbirth, postnatal and neonatal care, and birth spacing; with limited attention to hygiene and hand washing.

Achievements: With the help of local non-government organisations (NGOs), this study provided new and more detailed information about health care practices, including measures taken within the household, and preferences for health services at the village-level. It supplied insights into the processes of decision-making and action in rural communities, including choice of particular providers or services (traditional and biomedical), and the various factors that influence those choices. In particular, the study provided rich qualitative data in relation to three key scenarios: a child with diarrhoea, a difficult birth, and birth spacing (Zwi et al., 2009).

A 2015 evaluation of the *Liga Inan*[10] programme showing that women participating in it were twice as likely to give birth in a health facility, and seven times more likely to receive postpartum care than women who did not participate in the programme.

[10] The Liga Inan programme, Timor-Leste's first mHealth project, is changing the way mothers and midwives stay in touch. Women who participated in Liga Inan ("Connecting Mothers" mobile health program) received messages to their mobile phones about their health and the health of their babies during pregnancy, and for six months after delivery.

Challenges: Apart from Liga Inan, this programme had little focus on the demand-side (Kelly et al., 2019: 24). Health workers reported a range of limitations to delivering better services (Zwi et al., 2009: 10). These findings clearly demonstrate the urgent need for **greater communication and understanding** between those organising and delivering health services, and the communities for whom those services are intended.

USAID/NORAD: Results-based Financing for Maternal and Neonatal Health (RBF4MNH) Initiative, Malawi

The RBF4MNH Initiative was set-up to explore if the health-seeking behaviour of pregnant women in respect to maternal health service utilisation could be changed. The aim was to improve the quality of facility-based care provided to women and newborns during and within 48 hours after delivery.

The RBF4MNH Initiative was launched in April 2013 as a combined supply-side and demand-side RBF[11]. It was funded by USAID under Translating Research into Action, Cooperative Agreement No. GHS-A-00-09-00015-00. This study was also funded by the Royal Norwegian Embassy in Lilongwe, and the Norwegian Agency for Development Cooperation (NORAD).

Achievements: Overall, the impact evaluation detected an increase in the rates of service utilisation over time - although this increase was comparable across women residing in intervention and control areas. By 2015 (i.e. study endline), the proportion of women delivering in a health facility reached 95%.

Challenges: The RBF4MNH did not produce any increase in health service utilisation for directly targeted services (i.e. facility-based delivery) or for indirectly concerned services (i.e. antenatal and postnatal care services) (Brenner et al., 2016: 25). By 2015, the proportion of women seeking antenatal care in the first trimester of pregnancy, and the proportion of women seeking at least four antenatal care visits, remained relatively low, at approximately 20% and 50% respectively (Brenner et al., 2016: 26-27). A multi-agency evaluation for RBF4MNH found that this was due to **insufficiencies** in infrastructure, as well as lacking/ non-functioning equipment, lack of/interruption of continuous provision of essential medicines and consumables, and insufficient number and capacity of staff (Jordan-Harde, 2013).

4. Project challenges to consider

Maluka et al. (2020) conclude that improving early antenatal care attendance requires integrated interventions that address **both community and health systems barriers**. The following list is a summary of points for donors to consider for future RMNCH interventions for improving access to services, using evidence from both Ethiopia and other countries:

National indicator frameworks

Global and national investment into health monitoring and evaluation (M&E) systems in child health programmes has been insufficient, with a notable lack of training, supervision, and funding

[11] RBF refers to a set of financial arrangements linking payments to defined healthcare outputs (e.g. performance payments for service providers) or health-seeking behaviours (e.g. conditional cash transfers [CCT] or vouchers for service users).

for officers (Diaz et al., 2018). Surveillance, monitoring, and evaluation of malaria, HIV, TB, nutrition, and immunisation are usually done through separate donor funded programmes, with global disease specific guidance and reporting forms and single disease monitoring systems. This has further increased fragmentation as shown by uncoordinated parallel data collection systems, analysis of multiple data sources focusing on only one disease, and the lack of resources provided to other non-donor funded M&E programmes.

In alignment with the Sustainable Development Goals for MCH (SDG 3: Ensure healthy lives and promote wellbeing for all at all ages)[12], a set of indicators and an M&E framework has been developed specifically for MNC health (UNICEF, 2016; Diaz et al., 2018) but large gaps in data remain (WHO, 2016; Diaz et al., 2018). In part, this may be because these indicator frameworks are intended for global reporting.

Demand-side strategies

Lack of knowledge of the importance of seeking medical attention during pregnancy and labour is commonly believed to negatively influence health behaviour and decision-making processes. Elmusharaf et al. (2015) discovered three challenges that need to be addressed to create a supportive environment in which demand-side strategies can effectively improve access to maternal health services in Ethiopia. These are: **addressing decision-making norms, engaging in inter-generational dialogue, and designing contextually appropriate communication strategies**.

Address equity: disability

Despite so much effort being placed on improved access to maternity healthcare, studies show that women with disabilities are being systemically excluded from the mainstream maternal health services (Mheta & Mashamba-Thampson, 2017). Findings suggest that although women with disabilities do want to receive institutional maternal healthcare, their disability often makes it difficult for them to travel to access skilled care (Ganle et al., 2016, UN, 2019: 92).

This is also the case with seeking care for disabled children. A study on HEWs in Ethiopia noted that caregivers are often worried about being treated differently, feeling ashamed or embarrassed about their child's condition, and make efforts to keep their child's condition a secret (Miftah et al., 2017).

According to the UN Flagship Report on Disability and Development 2018, various countries have taken actions to address these challenges, including through development of national policies and programmes on sexual and reproductive health that are inclusive of persons with disabilities (UN, 2019: 94). However, Ethiopia is not one of these countries as it does not mention disability in its Reproductive Health Strategy 2006–2015[13] or 2016-2020[14]. Therefore, insufficient

[12] For full list of SDG Health targets: https://www.who.int/sdg/targets/en/

[13] https://www.who.int/reproductivehealth/publications/monitoring/ethiopia_access_rh.pdf

[14] http://corhaethiopia.org/wp-content/uploads/2016/08/RH-strategy-2016.pdf

collection and analysis of viable data and information on the situation of persons with disabilities regarding access to sexual and reproductive health services remains.

Address equality: gender

Gender equality is an issue in MNCH healthcare-seeking behaviour. The absence of many husbands is perceived to influence women's access to maternal health services such as antenatal care and institutional delivery, as women do not want to attend if there is no one to look after other children, the cattle, and the house (Jackson et al., 2016).

Gender issues are also reflected the views of in government officials. A study exploring perceptions of public servants in the Ethiopian health sector found that **women's presumed domestic obligations affected their ability to seek healthcare**. Men are thought to be gatekeepers for health service use by women (Bergen et al., 2020).

5. Lessons learned

Findings from a community cross-sectional survey by Ali & Woldearegai (2019: 292) implied the presence of a **positive health-seeking behaviour** among Afar that can be further strengthened with interventions promoting use of modern health services. The authors recommend that interventions should "address the misconceptions about causes/symptoms of illnesses, and promote appropriate hierarchy of resort to the utilisation of available healthcare services" (Ali & Woldearegai, 2019: 296).

The following are more lessons learned from donor RMNCH interventions outside of Ethiopia:

Cost of healthcare is not the only reason for health-seeking behaviour. Despite the availability of free healthcare, Sierra Leone continues to face significant challenges with respect to MCH (Sharkey et al., 2017). Many women still deliver outside of health facilities, and neither antenatal care nor postnatal care are always utilised in a timely manner. The social norm is to delay care-seeking until a pregnancy is visible, particularly in the poorer districts of Kambia and Pujehun.

When the **quality of services** in public clinics is perceived as low, even with low user fees, individuals, including the poor, may prefer to go to a private provider for care (USAID, 2008; Jalu et al., 2019). However, evaluation of the DFID Zimbabwe Maternal, Newborn and Child Health Programme found that **health-seeking behaviour among the poor remains lower than among the better off**, regardless of service availability and quality (Moore et al., 2015: 42).

Ownership of a Japan International Cooperation Agency (JICA)-funded MCH Booklet was positively associated with **higher health knowledge and proper health-seeking behaviour** among mothers in Kenya (Kawakatsu et al., (2015). Impacts of 5.9, 9.4, and 12.6 percentage points for higher health knowledge and for proper health-seeking behaviour for fever and diarrhoea, respectively, were statistically significant.

Care-seeking behaviour for maternal and newborn morbidities could be improved by interventions through **social platforms** such as women's self-help groups (SHGs), as was found by USAID-funded research in Uttar Pradesh, India (Araldus et al., 2017).

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